DPHHS-OM-300B
(Rev. 2/2008)

STATE OF MONTANA
Department of Public Health and Human Services

Return completed form, within three (3) working days, to
TSD/NCB/Security Operations Unit, 1400 Broadway Rm B204, Helena MT 59620 or FAX 444-5924

NON-DPHHS EMPLOYEE SYSTEM/FILE ACCESS REQUEST

Name of Individual Requiring Access: _____
(***Please Print***)
Phone: _____

Logon ID: _____ Create Logon ID: ☐ Yes

Agency: **DPHHS** Division: **Human & Community Services**

Employer: _____

Address: _____

CACFP
Early Childhood Services Bureau
111 N Jackson St 5th Floor
PO Box 202925
Helena, MT 59620

E-mail:

Access to: **CACFP Prod1** is requested.
(e.g., TEAMS, CAPS, PJUSTICE, AWACS, TSO, CICS, etc.)

If applicable, enter the required security class or security codes: **CACFP_USER_ROLE**

Justification: *(Give a brief description as to why access is needed.)* **The individual requiring access is a representative of a participating Child Care Facility and will be entering claims for reimbursement online at the website that interfaces with CACFP Prod1.**

List File Access: **None**

CONFIDENTIALITY/CONSENT STATEMENT: *(To be read and signed by the individual requiring access.)*

I hereby certify that I am entitled to the confidential client information to which I am requesting access. I will not release the confidential information to others unless it is for purposes directly connected to the administration of the program for whose purposes it was originally provided. Further release of this information may only be done upon authorization by the client whose privacy interest is involved or it may be released to others if specifically permitted by law. I understand that a violation of this policy may subject me to disciplinary action by my employer and may result in termination of my employer's contract with DPHHS. I have read the DPHHS Internet Policy and the State of Montana's Computer Use policies and I agree to comply with all terms and conditions. I agree that all network activity conducted while doing State business and being conducted with State resources is the property of the State of Montana. I understand that the State and Department reserve the right to monitor and log ***all*** network activity including E-mail and Internet use, with or without notice, and therefore, I should have no expectations of privacy in the use of these resources.

Signature of Employee: _____ Date: _____

Supervisor: Access for this individual is allowed for six months. I realize I will have to contact the DPHHS Security Officer if this employee needs access beyond the six months. I understand that it is my responsibility to inform the DPHHS Security Officer immediately when this employee terminates or no longer needs access.

Print Name of Supervisor: _____

Signature of Supervisor: _____ Phone: _____ Date: _____

Data Owner: _____ Date: _____

Security Officer: _____ Date: _____